World Health Organization
Regional Office for South-East Asia

JICA
Japan International Cooperation Agency

The JICA Reproductive Health Project in Madhya Pradesh

(JICA/MP - RHP): Lessons Learnt

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"Political commitment, policy and strategic directions and increased investment are making a huge difference to improving health and survival of women and newborn in India, and in Madhya Pradesh in particular. Increasing number of pregnant women are availing of the services at the faci
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for CLIC-CPHE
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21/11/11

FOREWORD

In the global context, for the Millennium Development Goal 5 (MDG 5) some countries are making progress, while in other the progress is slow. The latest maternal mortality ratio (MMR) estimates show an encouraging trend globally; however, w need to reaffirm our commitment and redouble our efforts and investment in high burden countries including those in SEA especially to redress inequities. Coverage of life-saving interventions including skilled attendance and emergency obstetri care at birth are still not adequate. The UN-MDG Summit and the launching of the Women and Children Initiative by the U Secretary General in September 2010 provided a powerful impetus for accelerating actions towards reducing maternal mortali

Like many other developing countries, India presents a mixed picture. A few states such as Tamil Nadu., Kerala and G have managed to reduce maternal, newborn and child mortality significantly, comparable to any developed country, but son states including Madhya Pradesh still have MMR that are unacceptably high. Even within these high MMR states, the urban-ru differrential is marked, and redressing this unacceptable inequity is urgently needed.

The Japan International Cooperation Agency (JICA) and WHO (Regional Office for South east Asia) share our feeling gratification for the successful completion of the JICA-funded Reproductive Health Project in Madhya Pradesh conducted fr January 2007 to January 2011, and for the documentation of the experiences and outputs of this project, funded by WHO-SEAR

The project itself, focused on maternal and newborn health in five rural districts in Madhya Pradesh owes its success several factors, not least being its ability to align itself to the aspirations of the National Rural Health Mission (NRHM) of Government of India, and to contribute to its implementation in the project area in Madhya Pradesh.

Too often, successful projects from which several lessons can be learned and which can provide examples of good practices, not sufficiently documented, or not documented at all, to benefit others. With this in mind, the purpose of this documentat is to share the unique experiences of the JICA-funded project with others, and we believe that this document can serve useful reference material for advocacy, policy planning, and programme implementation, besides being an important histor record and assuring "institutional memory".

WHO and JICA as partners in international health and development will continue to work with member states in our sh quest to accelerate further reduction of maternal mortality, and achieve MDG5. Improvements made in a few districts in Ma Pradesh will make a difference for the state, which in turn will make a difference for India. As India contributes a the lar number of maternal deaths globally, any progress made in India will contribute to achievement of MDG5 globally.

We take this opportunity to thank the Governments of India and Madhya Pradesh for having been supportive of this pr and of this documentation. We would also like to compliment the members of the documentation team for their relen effort to produce this useful document.

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EXECUTIVE SUMMARY

Political commitment, policy and strategic directions and increased investment are making a huge difference to improving health and survival of women and newborn in India, and in Madhya Pradesh in particular. Increasing number of pregnant women are availing of the services at the facilities. Maternal and newborn morbidities and mortalities are significantly declining. However maternal morality ratio and newborn mortality rates remain high in India, and some states – generally in the north of the country – including Madhya Pradesh have rates higher than the national average. In response to this, the Government of India has introduced several initiatives over the years – a major initiative being the National Rural Health Mission (NRHM) launched in April 2005 – to improve health care in rural areas.

In view of the commitment of the Government of Japan to support developing countries in improving their maternal and child health conditions, the Japan International Cooperation Agency (JICA) decided to support the Government of India (GoI) through the Madhya Pradesh Reproductive Health (JICA/MP-RH) Project with Phases I and II.

A "development study" on reproductive health in Madhya Pradesh was carried out between November 2000 and March 2002 to prepare for a pilot project in two districts of Sagar Divison, which was later scaled up to five districts. The project was implemented between September 2005 and January 2011 in two phases. The project aligned itself with the NRHM and focused on maternal and newborn health.

The key inputs and activities of the project revolved around four components:

- **Human Resource Management (HRM):** focused on capacity-building of frontline health workers for delivering quality maternal and newborn health (MNH) services at the district and block levels.

- **Total Quality Management (TQM)** aimed at improving the managerial skills of the health staff for improving the quality of services.

- **Health Management Information System (HMIS)** for improved collection and use of data, and more efficient use of information for evidence-based planning and management.

- **Information, education and communication/behaviour change communication (IEC/BCC):** to generate community demands through improved competencies of health providers and more efficacious outreach activities.

The project was led and managed by the Project Chief Adviser and a Project

Coordinator. Other members of the team, including a Project Operations Manager, were subsequently recruited locally. Monitoring of the project was carried out on the basis of the Project Design Matrix (PDM). A mid-term review (MTR) was conducted in February 2009 and a Joint Terminal Evaluation was conducted on August-September 2010.

The main purpose of this joint WHO-JICA effort to document the experiences of the JICA Project is to share the unique experiences of the same with other interested parties and stakeholders. A five-member team was formed to carry out the documentation. The methodology used was primarily qualitative, relying mostly on available secondary data in the form of several documents. In addition, primary data was obtained by stakeholders' interviews at various levels of service delivery and observations were made during field visits to a few health facilities.

There were salient findings from the execution of this project out of which useful lessons can be learnt. These can be perceived from five broad domains:

1. Aligning and optimizing the project with RCH-NRHM

The changes that had to be made because of the introduction of NRHM in the national health system were perceived as opportunities. A lesson to learn from this is that any project can be subjected to unexpected changes, but this need not be taken as a constraint. Indeed, if perceived properly, these changes can impart enhanced relevance to the project.

2. The organization and management of the project

The approaches used were useful: starting small with a plan to scale up; recruiting a few but appropriately qualified members for the project team; and having a well-formulated project design matrix (PDM) as a guide.

3. Improved quality of service

There was improvement in the overall quality of services in terms of:

I. Significant increase in the number of institutional childbirths: the number and proportion of institutional deliveries increased significantly since the project was implemented.

II. Enhanced midwifery skills of the health providers: the capacity-building activities, especially the six-day training, led to the skills, competence and confidence levels of health providers to be enhanced considerably and manifold.

III. Improved conditions for maternal and newborn care in health facilities: the project enhanced the utilization of the resources available within the system; efforts were also made to organize the "maternity wing" and labour room.

IV. Total quality management: This extended to biomedical waste (BMW) management which contributed towards reducing hospital-based infection and environmental hazards. There were other quality improvement activities including the introduction of the "quality circle (QC)", and functional analysis of health service delivery.

4. Better data and information management

A Maternal Health (MH) card to be used by ANMs was developed. The reporting system was improved by enhancing the data handling skills of data entry operators (DEO) through training.

5. Demand generation and improved perception of community

Community engagement and improved communication skills of ANMs led to a higher demand for services being carried out; along with an enhancement of the skills of the male multipurpose worker and supervisers. Women who use the health services were more aware about the importance of antenatal check-ups and the procedures thereof.

The documentation team identified some challenges in the health delivery system including, but not limited to, shortage of staff, inadequate skills of providers, poor conditions of health facilities, and poor information systems. The documentation process also identified factors that could have had a positive or negative influence on the implementation and outcome of the JICA Project.

Overall, the JICA/MP-RH Project has contributed significantly to improving maternal services in the project area. The project was successful in optimally using the resources made available through RCH and NRHM. Some of the experiences and products of the project can serve as "lessons learnt" and "good practice" models in maternal health for emulation.

1

Introduction

- Background : the situation in India
- JICA project in Madhya Pradesh
- The need for documentation

INTRODUCTION

Political commitment, policy and strategic directions and increased investment are making a huge difference to improving health and survival of women and newborn in India, and in Madhya Pradesh in particular. Increasing number of pregnant women are availing of the services at the facilities. Maternal and newborn morbidities and mortalities are significantly declining in India

1.1 Background situation in India

Despite of an impressive health infrastructure, in some states in India, pregnant women do not have timely access to life-saving obstetric care for complications. The lives of mothers and their newborn are threatened by the "three delays" – (i) delay in deciding to seek medical care (ii) delay in reaching a medical facility with comprehensive obstetric care; and (iii) delay in receiving quality care at the facility.

In India, maternal and infant mortality have been unacceptably high for many decades and did not change significantly, with a huge difference existing between states. The lowest record is in the southern states of Kerala, Goa and Tamil Nadu, and highest in the northern states of Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar and Chattisgarh as well as Assam and Orissa in the east. More than 50% of the maternal deaths in India are due to hemorrhage and hypertension. In 2005-2006[1], 28% of these deaths had not been checked even once during the antenatal period and 53% were not attended by skilled birth attendants during delivery. Skilled midwifery services, where it is most needed, is limited because of severe shortage of skilled human resources and the poor quality of public health infrastructure and facilities.

In Madhya Pradesh, a survey conducted in 2004-2006 revealed a maternal mortality ratio of 335/100000 live-births, compared with the national average of 276/100000 in 2005 (source: the UN interagency group for estimating MMR). Only one in five women (20%) received antenatal care. Even when women receive antenatal care (ANC), they do not serve most of the services needed to monitor their pregnancy. About two in five women who received ANC had their blood pressure checked (41%) or their urine tested (37%). Fifty-four per cent had their weight taken and 68% had their abdomen examined. Almost three out of every four births (75%) in Madhya

[1] *National Family Health Survey (NFHS) 3.*

Pradesh took place at home; only one in four births (26%) took place in a health facility. However, the percentage of births in a health facility during the three years preceding the survey increased from 13% in NFHS-2 to 20% in NFHS-3 among rural women.

This profile reflects the social, cultural, economic and political determinants of maternal and newborn health, of which poverty is the most significant. In response to the situation, the Government of India's Family Welfare Programme has made many strategic changes and introduced several initiatives. A major initiative is the National Rural Health Mission (NRHM) launched in April 2005 to provide accessible, affordable, accountable, effective and reliable health care in the rural areas of the entire country, especially to the poor and vulnerable

population. The NRHM aims to provide an overarching umbrella to the existing programmes of the Ministry of Health and Family Welfare, including reproductive child health (RCH) which had been realigned from the previous Child Survival and Safe Motherhood (CSSM) Initiative.

1.2 The JICA project in Madhya Pradesh

The Japan International Cooperation Agency (JICA) implemented in collaboration with the Government of Madhya Pradesh a project titled Reproductive Health project in Madhya Pradesh (JICA/MP-RHP) Phase I and Phase II – henceforth referred to in this document as "the project"–from September 2005 to January 2011 following a development study in 2000–2002. In line with the development of the health sector's policies and programmes of the Government of India and the state of Madhya Pradesh, the project underwent realignment and became an integral part of the National Rural Health Mission's (NRHM) Reproductive and Child Health (RCH)

Apart from JICA there have been several agencies operating in the area of maternal and child health in the state of Madhya Pradesh such as UNICEF, UNFPA, WHO, DFID. The Norway India Partnership Initiative (NIPI) also had activities in the state; and DANIDA had a project and a long term involvement in Madhya Pradesh

initiative. The goal of the project was to improve the quality of service delivery in reproductive, maternal and newborn health in selected areas in the state of Madhya Pradesh. However, in this phase of the project, its scope was confined to maternal and newborn health although there were indirect benefits to child health.

Apart from JICA there have been several agencies operating in the area of maternal and child health in the state of Madhya Pradesh. These involve UNICEF, UNFPA, WHO, DFID. The Norway India Partnership Initiative (NIPI) also had conducted activities in the state; and DANIDA executed a project and a longterm involvement in Madhya Pradesh and was also responsible for a significant share of all the primary health care infrastructure built in the state over the past 20 years. EC has been involved in a health sector reform project, called Sector Investment Programme (SIP), in Madhya Pradesh from 1998 to 2005.

1.3 The need for documentation

There were several specific features, characteristics, experiences and processes that were part of the project that are worthy of emulation by other states, districts or any other entity in India, and indeed by other countries. Realizing this, JICA forged a partnership with WHO-SEARO to embark on documenting the project experiences in order to serve as lessons that can be learned and emulated. The main purpose of this documentation is to share the unique experiences of the JICA project with other interested parties, and it can be used as a reference point for advocacy, policy planning, and monitoring, or simply as a historical record.

- Project planning
- Reproductive Health Project in Madhya Pradesh by JICA : Phase I
- Reproductive Health Project in Madhya Pradesh by JICA : Phase II
- Project components
- Project team and management
- Monitoring and evaluation of project

The JICA-MP Reproductive Health Project

Project Brief

The JICA-MP Reproductive Health Project

The purpose of the project was to provide technical cooperation to the Department of Public Health and Family Welfare (DoPH&FW), Madhya Pradesh state

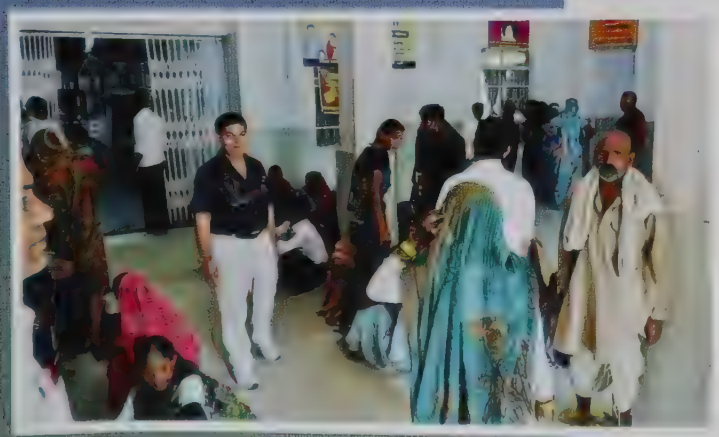
2.1 Project planning

In view of Japan's concern over issues of humanity, population and health including HIV/AIDS, the Government of Japan announced the Global Issue Initiatives (GII) on Population and AIDS in 1994, prior to ICPD. After 1994, it pursued the policy of promoting the Programme of Action (POA) of ICPD. India is one of the 12 priority countries identified by the GII.

Japan dispatched a project Formulation Mission to India in 1995, and an agreement was reached between the Japanese and Indian governments that assistance was needed to develop the district level master plan. A development study was then conducted for the improvement of women's reproductive health in Madhya Pradesh, a state which had poor indices of human development and women's health. This study was carried out by JICA between November 2000 to March 2002, and it revealed a gap in the reach of reproductive health services to women. The study suggested various inputs at the levels of programme management, service provision and the community for improving access and quality of service delivery to enhance the quality of life of women in the area. It identified two districts in Sagar Divison, Damoh and Tikamgarh as pilot sites. It then formulated a plan for improvement of reproductive health in these two districts, and to carry out technology transfer to the Indian counterpart throughout the study.

2.2 Reproductive Health Project in Madhya Pradesh, India, by JICA: Phase I

Based on the findings of the development study the JICA/MP – RH project, Phase I was initiated in 2005 in two blocks each in the two pilot districts of Hatta and Tendukhedah Blocks in Damoh; and Baldevgarh and Prithvipur Blocks in Tikamgarh. The purpose of the project was to provide technical cooperation to the Department of Public Health and Family Welfare (DoPH&FW) of the Madhya Pradesh Government for strengthening the reproductive, maternal and newborn health services delivery, focusing first on maternal and newborn health, so that the overall goal of reducing the maternal mortality ratio (MMR) and neonatal mortality rate (NMR) in the districts is achieved. The basic strategy of the JICA/MP – RHP is to start small and subsequently scale up. It can be summarized through the five letters of



the English alphabet from **O** through **S** as follows:

Operationalisation of NRHM/RCH-II through,
Pilot projects for,
Quality services, followed by,
Researches, and
Scaling up

Phase I of the project (September 2005 – September 2006) aimed to improve the MNCH services with the following expected outputs:

Output 1: Improved number of cases of skilled (birth) attendance at work.

Output 2: Improvement Quality of EmOC services at EmOC facilities.

Output 3: Improved community demand for quality of RCH services.

The main activity during this phase was human resource management (HRM), and about 130 ANMs, LHVs and staff nurses in the pilot districts underwent in-service training on antenatal care. This was followed by procurement of blood pressure monitoring instruments and stethoscopes which were not available in their duty station. The decision for the procurement of these sundry medical equipment was made by the project after the several discussions with the state government, and it was for the express purpose of ensuring quality of services.

2.3 Reproductive Health project in Madhya Pradesh, India by JICA – Phase II

Following the outcome of the joint review of Phase I, the Project Design Matrix (PDM) was developed (*See Annex 1*). This was followed by the commencement of Phase II of the project in January 2007 with a stipulated four years of cooperation until 2011. The relevant agreement documents between JICA and the Government of Madhya Pradesh were then inked. Although there was a gap between the end of Phase I and commencement of Phase II, field activities in the two districts were continued with the assistance of Indian consultants.

The scope of Phase II remained the same as with Phase I but it covered a wider geographical area, having been expanded to the five districts in Sagar Division with an area of 38428 sq km and a population was 6635720. The salient features of this phase of the project are described in the following sections.

2.3.1 Project components

The project activities revolved around the four main components, which are:

- **Human resource management (HRM)** focussed on capacity building of frontline health workers for delivering quality MNH services at the district and block levels.

- **Total quality management (TQM)** aimed at improving the managerial skills of health staff at all levels to ensure quality of service including clean and safe delivery of services, upgrading of health facilities, and effective management of biomedical wastes.

- **Health management information system (HMIS)** which was to improve the collection and use of data by ANMs and validation of data by LHVs; along with the use of computerized information for evidence-based planning and management.

- **Information, education, communication/behaviour change communication (IEC/BCC),** which improved the communication skills of providers, and provided outreach services, thereby generating demand for services by the community.

The four components were harmonized with one another, and they facilitated the creation of a service environment that can aspire to meet the Indian Public Health Standards (IPHS).

In 1994, Shortly before the International Conference of Population and Development (ICPD) in Cairo, the Government of Japan announced Global Issues Initiative (GII) on Population and AIDS and identified India as one of the 12 priority countries(ICPD) in Cairo, the Government of Japan announced Global Issues Initiative

2.3.2 The Project team and management

The project base was established by setting up the project office in Bhopal (the capital of the state of Madhya Pradesh). The project team was led by the project Chief Adviser and project Coordinator, both experts from Japan, who played the key roles of providing leadership ensuring overall management of the project, and coordination, especially with JICA country office and headquarters.

For coordination among the levels and teams in the project itself,including day-to-day operations at the field level, and especially to coordinate with the other government agencies at the national, state and district levels, a Project Operations Manager was recruited. Three national consultants and three technical coordinators were recruited locally. In the field, nine block coordinators were posted to the five districts. In addition, two Japanese short-term experts one each (for TQM and gender) joined the project for a short period of time. See Annex 2 for the organogram of the project.

Senior officials and frontline health workers from the state Department of Public Health and Family Welfare (DoPH&FW) contributed to the implementation of the project. Some of them were exposed to international trainings/workshops/seminars, in advance to strengthen their capacities. The project team also extended its technical expertise and shared its experiences at various forums at the state, national, and international level. In order to share the project experiences and lessons with more stakeholders, the project launched a specific website during the later part of Phase II.

2.3.3 Monitoring and evaluation of the project

Monitoring the progress of the project was done by the JICA India Country Office and JICA Headquarters, based on the provisions in the Project Design Matrix (PDM). Internal monitoring of the progress by the Project Chief Adviser was conducted regularly through the generation of GIS maps, direct on-site visits, and holding monthly and quarterly meeting with project members.

A mid-term review (MTR) of Phase II was conducted in February 2009 and a Terminal Evaluation in August – September 2010. After the MTR, the PDM was reviewed to make it more conducive to implementation. Before the Terminal Evaluation, the NIHFW conducted an external review of the project in mid-2010.

3

WHO-JICA Joint Documentation

- Objective
- The documentation team
- Methodology and data collection
- Limitations

WHO-JICA Joint Documentation

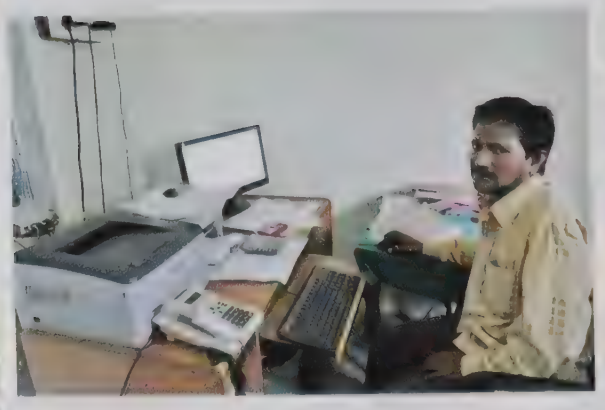
In concert with rapid progress of the national programmes NRHM/RCH-II, the first 14.5 months of the Phase II was highly productive.

3.1 Objectives

As mentioned in the Introduction, the main purpose of this documentation is to share the unique experiences of the JICA project with other interested parties, either to serve as a reference for advocacy, policy planning, monitoring, or as a historical record, but more importantly to share experiences and lessons in the event any party wished to embark on a similar enterprise.

3.2 The Documentation Team

A five-member Documentation Team (*Annex 3*) was formed comprising two senior officials from WHO-SEARO, one from the JICA India Country Office, one ex-JICA project consultant, and one external consultant hired by WHO-SEARO. The team members visited various facilities in the project area, including clinics, hospitals and ANM training centres. Several stakeholders from various categories were interviewed, representing the



Department of Public Health and Family Welfare (DoPH&FW) at the state, district and sub-district level.

3.3 Methodology and data collection

The documentation was carried out in August-September 2011, using primarily a qualitative methodology which relied mostly on available secondary data in the form of project design documents, assessment and evaluation reports, meeting reports, technical material produced by the project, as well as relevant reports produced by the Government of Madhya Pradesh and of India and other development partners.

Primary, data was collected through site visits and a quick compilation of stakeholder responses at the policy and programme level (at the state and district health departments). It was also collected at the service provision level, involving providers and clients (mainly antenatal mothers) as users of service. Observations were also made of contacts between providers and clients. For collection of this primary data, a purposeful sampling was employed whereby the four blocks in the two pilot

The team members visited various facilities in the project area, including clinics, hospitals and ANM training centres. Several stakeholders from various categories were interviewed

districts of Damoh and Tikamgarh were selected. Of the additional three districts in the scale-up phase, one block was randomly selected from each district. Visits were made to all the levels of service provision: SHC, PHC, CHC. Inferences were drawn by triangulating this primary data from interviews and observations with the secondary data.

3.4 Limitation

The process of documentation of JICA/MP-RH project was conducted six months after the project ended and the team disbanded. Therefore, many of the team members were not available for the interview, including the Project Chief Adviser and Coordinator. The documentation had to be conducted within a short period of time, requiring rapid methods that did not allow a scientifically robust approach.

The process of documentation of JICA/MP-RH project was conducted six months after the project ended and the team disbanded, therefore many of the team members were not available for the interview, including the Project Chief Adviser and Coordinator

4

Findings and Lessons learnt

- Aligning and optimising the Project with RCH-NRHM
- The organization and management of the project
- Quality Improvements in service delivery
- Better data management and supervision
- Demand generation for services and community perception

Findings And Lessons learnt

Lessons learnt

- Changes to any programme or project can occur for a number of reasons, and change has to be adjusted and managed appropriately
- The changes from the NRHM were seen as opportunities for the project because they provided clear strategies, principles and approaches, not as difficulties
- The specific features of the NRHM such as the JSY was an exceptionally relevant opportunity for the project for increasing demand
- Effective leadership is essential in managing change

There were salient findings from the execution of this project from which useful lessons can be learnt. These are organized below under five broad domains. These are not presented according to the four components because several activities and inputs can pertain to more than one component. These findings are based on triangulation of various information:

(1). How the project aligned itself with and optimized the RCH-NRHM, and facilitated the implementation of RCH-NRHM in the pilot districts in Madhya Pradesh.

(2). How the project was planned, organized and managed.

(3). Quality improvement: what difference in quality has been made from the key inputs of the project which include the following (information system is discussed separately below):

- Increased numbers of institutional childbirths.
- Enhanced midwifery and management skills of ANM, LHV and staff nurses.
- Improved service delivery conditions in facilities.
- Improved clinical waste management as the entry point for TQM.

(4). Improvement and innovation in data and information system.

(5). Demand generation and perceptions of the community.

4.1 Aligning and optimizing the project with RCH-NRHM, and facilitating implementation of the State Plan for RCH-NRHM

The following are an assortment of responses received from stakeholders on various elements of the project:

"...very innovative...very daring, whatever new policy the government has...there was a need to unpack the policies... something that is challenging for all... going to field...translate things...the beauty of the project – whatever policies came, we made it happen...what was required, that to help the frontline..." (Response: Ex-HMIS consultant, JICA/ MP-RH project)

During the process of negotiation at the start of the implementation of the project, several changes were taking place in the Family Welfare programme in India. In 2005, Government of India launched the second phase of the RCH Programme under the larger umbrella of National Rural Health Mission (NRHM). By the time the one-year Phase I ended in 2006, the detailed framework for implementation of NRHM was already available. Therefore, it was necessary for the project to align itself and be in consonance with these changes. This turned out to be an opportunity for the JICA project to optimize the national policies with regard to RCH-NRHM, and its implementation at the state and district levels. It was initially feared that this reorientation could create difficulties with those team members who had familiarized themselves with the original proposal and PDM. However the project leader's ability to lead and motivate the team, and to manage change effectively, were useful when this realignment occurred.

4.2 The Organization and Management of the Project

In Phase I, the project had only Japanese expert: the Project Chief Adviser who continued working for phase-II. Later, a TQM consultant was hired and also an HRM consultant to assist in training. In the early part of Phase II, the technical experts recruited by the JICA project gradually joined to complete the team. With the project base being located in Bhopal, away from the districts where the project was being implemented, good management and especially competent supervision skills were required. District-level coordinators were recruited for monitoring and supportive supervision. That was followed by recruitment of block coordinators to oversee the day-to-day implementation in their respective blocks. These team members were recruited based on their subject-specific knowledge and experience, but the approach of learning by doing adopted by the project gave everyone the opportunity to learn, enhance and share their pool of knowledge.

The deliberate approach of starting small and take small steps with a gradual scale up, expressed as "zero to one" approach, could have been mistakenly perceived as something that compromises visibility and therefore reduces the relevance and credibility of the project. But, in the end this approach proved to be useful

because it made the managers more confident without having to be faced with high standards and unrealistic targets at the beginning of the project, which is the learning phase. They were also more confident of themselves and of the project because further steps were taken only after success was visible, and this made them more keen to register success at each step of the way.

The Project Design Matrix as shown in Annex 1 was a very useful guide to "navigate" the project throughout its implementation, and it provided a

The key inputs from the project made a difference in the quality of reproductive and MNCH services in the pilot areas.

mechanism to track the progress of each of the components of the project. The PDM outlines the overall goal which was stated as "The state health sector to ensure quality mother and newborn child health services". The purpose of the project was to "increase the number of pregnant mothers who receive quality maternal care by the nursing cadres with special emphasis on ANMs", and for this five expected outputs were identified in the PDM. Verifiable indicators and mode of verification were identified for the overall goal, the project goal and the five outputs. To ensure that the PDM was useful at operational levels, specific activities were identified under each of the five outputs with the relevant inputs for the conduct of these activities factored in.

4.3 Quality Improvements in Service Delivery

The key inputs from the project made a tangible difference in the quality of reproductive and MNCH services in the pilot areas. A significant output was achieved in the numbers of institutional deliveries, which probably resulted from two major inputs – enhancement of midwifery skills of health providers and improved conditions at facilities – although the role of the Janani Surakshya Yojana (JSY) scheme could not be disputed. Another input of the project as the entry point for TQM was the management of biomedical wastes (BMW). Data and information system improvement was also another major input and will be discussed separately in the next section.

4.3.1 Significant increase in institutional childbirths

To reduce maternal mortality, several efforts were being made by the health authorities of the RCH-NRHM of the state of Madhya Pradesh. These include efforts to enhance the number of functional delivery points in order to increase the number of institutional delivery. The provision of transport to the health facility (Janani Express Yojana in Madhya Pradesh) and incentives to mother as well as the ASHA worker through the JSY (Janani Surakshya Yojana) scheme for institutional deliveries under RCH II have led to a substantial increase in institutional deliveries[2]. Data from the MIS of NRHM upto March 2011 revealed a significant increase in deliveries conducted by skilled birth attendants (SBA). The 4th Common Review Mission (CRM) of December 2010 reported that only 18% ANMs, 24% LHVs, and 34% staff nurses had undergone SBA[3] training. Although the proportion of ANMs having been trained was relatively low at only 18%, this did not compromise the proportion of deliveries by SBAs since a large number of deliveries were happening in facilities.

The increase in institutional deliveries between 2005-2006 to 2009-2010 was remarkable. As seen in Figure 1, the two pilot districts recorded the most significant change in share of institutional childbirths between 2005-2006 to 2010-2011, i.e. from 24% to 87% in Tikamgarh and from 13% to 71% in Damoh. In the non-project district of Raisen, an increase was also observed but the magnitude of the change was relatively smaller. It must be kept in mind that the NRHM was introduced in 2005, and the JSY scheme started to have an appreciable impact after 2006 throughout the state. It is reasonable to infer that these two initiatives, the JSY of NRHM and the JICA project, have acted in synergy to produce this encouraging trend in institutional deliveries.

Fig 1: Trend in institutional deliveries in selected districts of Madhya Pradesh 2005 – 2011

	Madhya Pradesh	Tikamgarh	Damoh	Panna	Chattarpur	Sagar	Raise in Non-JICA districts
2005-06	34.90%	24%	13%	24.80%	27.60%	24%	20.80%
2009-10	80.25%	76%	67%	89.30%	89.60%	58%	75.70%
2010-11	84%	87%	71%	92%	89%	62%	77%

Source: CNAA – RCH – MP[4]

[2] *4th Common Review Mission Report, Madhya Pradesh, December, 2010*

[3] *SBA (skill birth attendant): a 21-day training for ANMs, LHVs and staff nurses encompassing antenatal, intranatal and postnatal care being conducted at the District Hospital for each district in the batches of four.*

[4] *http://www.health.mp.gov.in/bulletin.htm*

Lessons learnt

- Starting small with a plan to scale up gives confidence to members through learning by doing, and allows for setting and meeting moving targets
- Although the number of manpower is relatively small, a project of this nature can benefit from qualified staff with the right motivation, aptitude and attitude
- A well-formulated project design matrix (PDM) is an extremely useful tool for managing the project; it guides and navigates the steps of the project

4.3.2 Enhancement of midwifery skills of ANMs, LHVs and staff nurses

This key input as part of the HRM component of the project had the most perceptible impact in terms of improved competencies and raised confidence levels of frontline health providers. The increasing trend of institutional delivery described above would have required more ANMs, LHVs and staff nurses available at all levels of facilities round-the-clock (24 hours a day, seven days a week) The reality on the ground is that there is perpetual staff shortage, which is a common feature of health systems in developing countries including India and the state of Madhya Pradesh is no exception. In Table 1, with data obtained from the 4th CRM Report, it is observed that except for ANMs (who were is in excess by 16%), all other cadres were in short supply with deficits as high as 61%.

Besides ensuring adequate human resource, the skills and confidence levels of these providers are also crucial. This is an area that was addressed by the project, and the impact was clear and durable. In Table 1, it is seen that SBA training had been attended by 409 out of 2044 LHVs, and 1154 out of 3867 staff nurses in the state. The number of ANMs having undergone the same training which is, 2210 out of the 10490 ANMs in the state, suggests that more need to be trained, since skilled birth attendance is one of the pillars of safe motherhood and is also a benckmark for the UN Millennium Development Goal 5 (MDG5A).

Increasing the quantum of human resource and addressing the human resource gap was beyond the capacity and mandate of this project. However, the project paid particular attention to improving the core competencies of frontline maternal health providers, such as screening high-risk pregnancies by registering pregnancies early in the first trimester and ensuring at least four antenatal check ups, conducting normal deliveries safely, timely management and quick referral of complicated cases to nearby FRU, and providing postpartum care to mothers and early neonatal care to newborns. This aspect was singularly successful in the project. By the end of the project in Phase II, most of the ANMs and LHVs of Damoh and Tikamgarh

Table 1: HR status and SBA training attended by ANMs, LHVs and staff nurses in Madhya Pradesh

Category	Sanctioned	In position		Shortfall	Percent shortage (%)	SBA training attended
		Regular	Contractual			
		NRHM funds				
Doctors	3790	3583		207	5.4	
Specialists	3057	1177		1880	61.5	
LHV	2044	1618	62	364	17.8	409
Staff nurses	7309	3095	347	3867	52.9	1154
ASHAs	52177		50113	2064	3.9	
MPW	7933	6037		1896	23.9	
ANM	10492	10373	1810	1691 (Surplus)	16% (Surplus)	2210
Lab technician	1415	1058		357	25.2	
Pharmacist	2262	1520		742	32.8	
X-ray technician	667	427		240	35.9	

Source: 4th CRM Report, Madhya Pradesh

district had undergone the six-day ANC training, while some from the district of Panna had been trained using the two-day module.

During the field visits to various health facilities, interviews with ANMs and LHVs who were trained in the core competencies of antenatal care reiterated the need of continuing such training for ANMs. It was also felt that there is a need for adding activities such as a short orientation of staff nurses, on-the-job training, supportive supervision and the like.

The project designed the details of the ANC training including features such as methodology, training material, the mechanism of conducting training, as well as on-the-job follow-up to reinforce skills development. These complemented

"...at all levels we are running the programme with 40 to 45% staff strength..."

Response of Divisional Jt. Director, Sagar Division, Public Health & Family Welfare, Government of Madhya Pradesh, Bhopal

"...earlier ANC was mostly limited to Iron/Folic acid provision and TT but JICA could bring the additional elements of antenatal check up...I met the ANMs trained by JICA...the level of confidence the JICA project area ANMs had..."

Response of Mission Director, RCH-NRHM, Public Health & Family Welfare, Government of Madhya Pradesh, Bhopal

" ..skills improvement training by JICA was very good for ANMs.. overall MCH services in those districts improved because of them "

Response of Joint Director, Sagar Division, Public Health & Family Welfare, Government of Madhya Pradesh.

the efforts of the government to fast-track the training of skilled birth attendants in response to the government's policy and commitment to phase out deliveries by traditional birth attendants (TBAs) and to ensure that all deliveries are conducted by an SBA with the required level of proficiency.

The ANMTCs[5] trainers underwent the Training of Trainers (ToT) conducted by the project to enable them to carry out the six days of training on ANC for ANMs and LHVs. In addition, the project also extended technical support to trainers/ facilitators at the district hospital within the project area to organize the 21-day SBA training, which was being carried out by the DoH&FW in the entire state.

[5] *ANMTC – Auxiliary Nurse Midwife Training Centre – conducts 18 months pre-service training for ANMs and are also engaged in 21 days Skilled Birth Attendants (SBA) Training, being carried out in the state.*

[6] *SIHMC – State Institute of Health Management and communication is the SIHFW (state institute of health & family welfare) of MP*

[7] *RFWTC – Regional Family Welfare Training Centre*

Training of Trainers through workshops was also organized by the project for trainers and faculties of SIHMC[6] and RFWTC[7], who also were responsible for conducting training for ANMs, LHVs and staff nurses. Arrangements were made to ensure that the training was conducted smoothly. For example, since Damoh did not have a ANM training centre, arrangements were made for the ANMs from this district to be trained at the training centre in Sagar.

The six-day training was considered appropriate, and there was evidence from the pre – and post-training evaluations that it was effective. However, after much deliberation it was deemed that this six-day module may not be practical or feasible for scaling up for the state once the project ended. Therefore a two-day training on ANC core competency was field-tested in Panna and Chattarpur districts, and this was found to be acceptable.

Thus, the project once again successfully aligned itself to the needs and situations of the health system. This was further strengthened with the contributions made by the two experts in the project team (HRM and TQM experts) who were invited to be members of the Expert Group that was developing for the Government of India the national guidelines for SBA training. The two experts advocated to the Expert Group in favour of placing emphasis on "ANC" in the SBA training, as this emphasis was proven to be a major success factor in the

HRM component of the project. This this led to the guidelines being titled "ANC and SBA Training Guidelines".

Interviews with and observations of ANMs, LHVs and staff nurses in the project and non-project areas (blocks) revealed a difference in terms of their interaction with antenatal mothers and ability to provide essential MNCH services. Interaction with stakeholders at various levels revealed that the training of ANMs conducted under the project was one of the key inputs in enhancing their skills and confidence levels over providing maternal health-care services. Clients who interacted with the service-providers expressed their satisfaction as well as appreciation. This reflected the approach and scope of the training, and the fact that training was not restricted to only technical aspects of maternal and newborn care but also included the enhancement of skills in communication, presentation through posters, role plays, and community mobilization.

In order to practise their newly acquired skills the health providers expressed the need for the supply of minor equipment essential for providing MNCH. They were grateful and appreciated the same and appreciated the "small gestures" of the project in providing blood pressure monitoring instruments, stethoscopes, weighing machines, Hemoglobin estimation strips, uristrips for albumin

and sugar estimation in urine, needle destroyer, and the like. Even a well-designed carry-bag given to ANMs (to carry essential equipment, registers and medicines during their community outreach), was appreciated by ANMs and health facility staff.

In addition the JICA has also supplied few equipment for maternal and newborn care, based on needs, to the District Hospital in Damoh and Tikamgarh, as well as to some CHCs and PHCs in both the districts. It was a timely intervention by the project, because technical support to strengthen health services delivery needs to also look into the availability of material and equipment to enable practical learning as well as to practise their skills in order to render quality service.

Most of the key informants for programme management including the ANMTC trainers spoke about the way this project has enhanced the capacities of ANMs, LHVs and staff nurses through not only ANC training

"...100% of the ANMs being able to recall what they have learnt. Practical sessions for core competency skills like BP measurement, FHS etc. have led to a feeling of empowerment and increased their self confidence..."

External Evaluation Report of JICA /MP Reproductive Health Project in Tikamgarh and Damoh District, MP, 2010 by NIHFW, New Delhi, India

Lessons Learnt

- Based on the experiences of the project, strengthening of midwifery skills of ANMs, LHVs and staff nurses can be institutionalized and scaled up if the capacity of district-level managers and trainers is upgraded to address "quality" without undermining the current load of SBA training.
- The state-level institutions such as SIHMC and RHFWTCs can be utilized for ToTs for district-level trainers to improve the methodology of the training that imparts practical skills.
- The supervisory cadres such as DPHN and additional staff nurse assigned at the block level to work as BPHNs need to take the lead for "on-the-job training" and "supportive supervision" with the help of "standardized guidelines" on consultative supervision.
- Engaging DPMs, MOs, BPMs, LHVs, male supervisers and staff nurses in the supportive supervision is also crucial. The knowledge products produced by JICA/ MP-RH Project are available to take this ahead.
- A model of training, while appropriate in a project environment, may not be so in "real life" in which there are constraints in the health system; therefore, adjustments may need to be made. This was exemplified by the redesigning of the six-day training on ANC competencies to a two-day training.

but also "hand-holding". They also spoke of the need for on-the-job training and regular supportive supervision by the block coordinators of the project. A case control study was conducted by the Bundelkhand Medical College in Sagar to compare the performance of ANMs in the project area (who had undergone the six-day training) with those from a non-project area. (*see Box*)

Based on their experience, the trained health staff developed the following documents and knowledge products that can be used in similar situations elsewhere.

I. Methodology paper: guidelines for block level orientation on core competency.

II. Training modules and aids (for trainers as well as trainees).

III. Guidebooks and monitoring tools for tutors (facilitators).

IV. Self teaching tools for health workers (trainees).

V. Guidelines for supervision (for supervisors).

Case control study to assess the impact of six-day ANM training revealed a significant difference in the levels of practical knowledge and practical skills on ANC among:

- ***ANMs in Damoh district, trained by the project.***
- ***ANMs in Sagar district not trained by the project.***

Sampling: 30 ANMs each from three randomly selected blocks in each district.

Methodology: (i) semi-structured questionnaire to assess knowledge; (ii) direct field observation to assess antenatal check-up skills.

Conducted by Bundelkhand Medical College, Sagar, Madhya Pradesh, 2011

Skill and competency development through planned measures such as the training conducted for ANMs in this project, will not only leave an impact on the technical performance of the health provider but also on the dedication that she puts into her work. (see story in Box 1).

It is also to be recognized that improved skills, a high degree of commitment and dedication will need to be supported by an enabling environment. The story in Box 2 shows how an ANM training centre has been provided with facilities that have made a difference to the attitude and well-being of both tutors and students. The same story also relates that it is possible to aim for high standards – as in a world-class neonatal ward at a district hospital. These stories were narrated by the documentation team members from their observations and interactions with these health providers

STORY 1: DEDICATION AT WORK

This PHC seemed to be in the middle of nowhere, and by the side of a main road. We could see houses and localities in the distance. Perimeter walls are being built to protect the PHC and the staff houses. We were greeted by a young, enthusiastic and confident ANM, mother of a young child. Her child is with her mother in her village so that she can devote all her time at the facility.

We entered a clean room of the ANM flushed with bright sunlight. The ANM guiding us was explaining that the windowpanes had been repaired recently, as it was broken by children from nearby villages hurling stones during play. JICA had negotiated with the local authorities to build the perimeter wall, still being completed, and had replaced the broken panes with new ones. She said she was happy that the windowpanes were now intact.

JICA had provided the haemoglobino meter; we were not sure if and when last it had been used.

The ANM not only attended to childbirths or conduct ANC, but also treated common illness. It was a busy day, just like every day, but she always had that confident smile on her face.

She took us to the delivery room. The windows were new with the panes intact and the room had a new and wide entrance door but with no curtains, though! In the middle, as in most of the delivery rooms in public health facilities, there was the old-fashioned, high, so-called delivery bed made of steel and without any mattress. At the corner there were some instruments.

On the other side there lay the newly purchased equipment for newborn care, and most of them seemed to have not been used till then. The delivery room had white tiles, and was clean. That very morning she had delivered a baby in that room. She explained that before the JICA intervention, the windowpanes and even the entrance door had been broken, though the floor and walls did have white tiles. On a windy day or if it was raining, she had to ask someone to hold a cloth against the window and at the door while delivering a baby. She said she was happy that now she could work more comfortably and deliver babies in a room better provided.

She wanted us to see where she lived and also took us around the staff houses within the compound. The staff nurse was called to a higher facility some time back leaving her alone to care for the PHC. There was no doctor assigned there

While she was narrating her story we saw the pride in her eyes about what she did and her contributions and achievements. The number of deliveries, however, were decreasing compared with other years since more and more women were going either to the sub-centres (which had been converted) near their houses or to the district hospitals or CHCs for delivery. She was very confident that more and more mothers were coming to the facilities for childbirth.

In case of complications during a childbirth, she would call for transport and send the mother to the next high facility, a few hours' drive from there. The road, however, was very badly maintained road and littered with potholes. In the rainy season in particular it is was a difficult and long journey. There had been no maternal deaths but a few stillbirths were recorded in the last few months in this PHC.

We left wondering what would happen at night if a pregnant woman would be in labour and come to the facility. What options would these women or the ANM have at that time?

She wanted us to see where she lived and also took us around the staff houses within the compound. The staff nurse was called to a higher facility some time back leaving her alone to care for the PHC. There was no doctor assigned there. Almost all the windowpanes in the houses were broken and had been boarded up with cardboard papers. Grass, bushes and shrubbery had grown wantonly tall around the building and had not been trimmed or attended to for long.

She told us with a shy smile about the number of times she had to confront with snakes that had slithered into the building or when she would be on her way to work at night.

We wondered about the nature of electricity supplies in her staff quarters or the security provided to the young ANM at night, but we didn't dare ask her these questions. There were two general staff members working in that PHC who were responsible for keeping the facility clean. They were begging with us to pitch for a pay hike for them, which they said was long overdue. The untiring energy, dedication and unwavering willingness of those staff members and the ANM in particular was astounding. The ANM was living without her young child and worked all alone in that facility only to save the lives of other women and children! This was commendable indeed.

Just as we were leaving we saw a truck pulling into the facility with a new toilet seat. There is always room for improvement!

STORY 2:
THE WONDERS OF AN ENABLING ENVIRONMENT

Leaving the District Hospital behind and driving along the rainwater-filled potholes, we arrived at the ANM training centre. Rushing inside to avoid the rain and dexterously avoiding the puddles and slush pools in front of the centre. As we walked in we were greeted by the smell of fresh, warm chapattis being baked. Two ladies were busy making chapattis in the corridor just near the entrance!

The venue was a big school with dormitory facilities for students. We were welcomed by an elderly lady of a very gentle disposition; the head of the centre. She invited us to her room. It was full of wooden cupboards. She sat behind the desk and we sat on the chairs around it. Just next to the door on the floor was a new air-conditioner that seemed just to gather dust. It was supposed to be fixed to the wall a very long time ago!

We were joined by another tutor. Both were very experienced trainers and had been in this job for a long time. Both of them had had refresher training years ago and some more training by JICA with the Training of Trainers' modules for ANMs recently. We were talking about the new ANM students. Some of those selected, we were told, didn't have the required basic education, and lacked adequate reading and writing skills too! The training should ideally be residential but some trainees – particularly those without adequate basic education – did not stay at the school dormitory but commuted from their homes in the town. As a result, they often missed their classes or arrived late. The tutors could do precious little to discipline them on this score.

Even as we spoke the electricity supply went on and off a number of times. We left the two of them with a humbling sense of amazement at their practical knowledge, dedication and commitment. They were totally devoted to their school and students despite all the constraints!

Hands-on training on midwifery was provided at the district hospital by the midwives or doctors stationed at the hospital but under a different administration. The district hospital records thousands of deliveries every year, and hence it was ideal for students to receive their competency and skills-based training there. We were not sure of or not very clear about the supervisory procedures or training methodology of the skills-based training or the procedure adopted for evaluation of skills of the student ANMs. Because of the paucity of tutors at the training centre, the tutors may not be able to assist or guide the students when they served in the maternity wards. We also could not ascertain how much orientation or training was imparted to those midwives or doctors responsible for providing skills-based training. The quality of maternity wards with prenatal and postnatal mothers and their newborns admitted, or the standards in place at the delivery room of the hospital left much to be said, but that was another story for another day!

But the district hospital threw up quite a contrasts, what with the newly-built neonatal ward of international standards, the air-conditioned rooms and the sophisticated incubators. It was quite amazing, and it's possible!

We met the ANM students in their classroom. It was a big class room, with chairs for students and a backboard and tables for the tutors. The students were a group of very young, shy, polite girls with bright eyes and minds brimming with questions and the eagerness to learn. Many of them had had a college education, and had heard about the training and the job it offered and applied because they also wanted to serve their people. They appreciated the importance of what they were being taught! We were told that the school had mannequins as teaching aids. Perhaps they also had video or projection facilities and computers. May be they have modern technology for training! May be those elderly tutors are familiar with these new ways of training!

The rain poured incessantly. As we said goodbye to the tutors and the students and walked along the corridor, we passed old cartons, dust-laden instruments and other material littering the floor. One of the female visitors wanted to use the washroom but she was told in a hushed whisper not to do so... but hold on, that's yet another story!

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"...some of the SHCs became delivery points...in CHCs, there were significant improvements... particularly the maternity wing...they introduced the 5 tray system...also 24x7 health facilities to have "staff duty register"...update regularly and put it on wall...maintaining partograph, was also introduced by JICA...management of 3rd stage of labour...early initiation of breast feeding...

Response of Mission Director, RCH-NRHM, Public Health & Family Welfare, Government of Madhya Pradesh, Bhopal

4.3.3 Improving service delivery conditions in the health facility:

The framework of RCH/NRHM adequately addresses the need for improving the service delivery conditions in rural public health care facilities, but several systemic bottlenecks in the public health service management are common constraints for their operationalization. It is evident that without improvement of maternity facilities and without an adequate number of maternity beds at the sub-district level providing "24x7" maternity care services, and without facilities with their existing bed and birthing facilities, quality, clean and safe childbirths, and retention of mother and newborn for 48 hours in the facility will not be guaranteed to ensure postnatal and newborn care (a norm required by JSY scheme). The currently available number of beds at health facilities and the standard norms for beds (CHC: 30, PHC: 6, SC: no beds) are not adequate to meet the demands of the increased load of institutional delivery in these "24x7" facilities.

The project attempted to include this in its scope, but it is an extremely difficult task for a project that is funded externally, JICA being an external agency. The project, however, managed to facilitate the utilization of the available resources within the system, which was an appropriate input for the TQM component. The project assisted health staff to

organize the work processes in the CHCs based on the IPHS[8]. It also assisted and showed the ANMs how to utilize the untied government funds under the NRHM for renovation of health facilities.

The efforts made in organizing the "maternity wing" including the "labour room" in a few PHCs in Damoh and Tikamgarh districts have left a positive and lasting impact as noticed even six months after the project ended. The project developed an *Illustrated* guideline for Maternity Wings in District Hospitals, CHCs and PHCs.

Some examples of inputs that improved the conditions in the facility are improvement in overall cleanliness; regular updates and display of staff duty rosters; dress code for staff; "four corners[9] and five trays[10]" in the labour room; use of "partograph" to monitor the progress of labour; and display of SoPs/guidelines on the walls of the labour room. A few parameters of these initiatives in the maternity wing are shown in Table 2.

The project also made a visible difference in the way the sub health centres (SHCs) were functioning. The

Table 2: Status of maternity wing in CHCs at end of Phase II of project

'Maternity Wing' organization status by the end of Phase II, JICA / MP-RH project						
	Districts					
	Damoh	Tikamgarh	Panna	Sagar	Chattarpur	Total
No. of existing CHCs	7	6	6	11	10	40
With Duty Roaster	6	2	2	9	2	21
With 5 trays	7	1	1	8	0	17
With 4 corners	5	2	2	8	1	18

Source: Joint Terminal Review Report, JICA / MP-RH project Phase II, September, 2010

[8] *Indian Public Health Standard (IPHS) guideline for CHC, PHC & SC, by MoH&FW, GoI, 2010, http://mohfw.nic.in/NRHM/iphs.htm .*

[9] *Four corners: Observation corner, service station, labour corner, newborn corner.*

[10] *Five Trays: Delivery tray, episiotomy tray, baby tray, medicine tray for delivery, emergency drug tray*

Lessons learnt:

- In terms of improving human resource, the training conducted has left a positive impact on the skills and competencies of service providers and increased facility childbirths by clients. This training is not difficult to replicate, it is a package of not only in-service participatory training on midwifery skills with the help of appropriate training aids but also on-the-job practical orientation on a continuous basis while providing moral support through supportive supervision.
- This enhanced set of competencies, increased confidence and higher motivation were also utilized for improving the conditions at the health facility, especially at the maternity wing and labour room.
- Support is needed for this, and for other matters such as ensuring uninterrupted supplies.
- Medicines, helping in improving the working condition, enhancing their abilities to understand the importance of information being collected – all has to be packaged well – to ensure empowerment of frontline worker to provide good quality maternal health services.

ANMs were assisted by the project team to reorganize the facility by way of better utilization of the space and resources available, especially the untied funds under the NRHM and the maintenance funds. It was extremely difficult for the ANM, when in addition to her work in the field she was provided "untied funds" of Rs 10000 to upgrade and maintain the health facility without being trained or guided on how to manage and use this fund.

These improved conditions in the facilities further accelerated the government's efforts to enhance the quality of services at the SHC. For example, it complemented the policy of the creation of a second ANM position at the SHC, by which it was expected that these centres can function as "24x7" centres and that their work performance would also be enhanced especially to the conduct of normal deliveries making appropriate and timely referral of complicated deliveries to the nearest CHC or district hospital, and providing better outreach services. The ANM is also supposed to work with ASHAs[11] and AWWs[12] to reach out to women and children in the villages within her sub health centre area. Some of the SHCs which were not providing "24X7" service began to do so, and a few were even accredited by the district health authorities to start conducting deliveries. For example, the SHC at Taradehi in Tendulheda block of Damoh district started conducting deliveries from August 2009 and since then has recorded an increasing tend in the number of deliveries as shown below in Table 3. Table 4 depicts the number of centres that were accredited to conduct deliveries in the districts of Damoh and Panna.

Table 3: Trend of deliveries conducted in SHC Taradehi in Tendukheda block

Time period (duration)	Number of deliveries	Average per month
August 2009 to March 2010 (8 months)	123	15.4
April 2010 to March 2011 (12 months)	405	33.8
April 2011 to August 2011 (5 months)	190	38.0

Source: Joint Terminal Evaluation Report, JICA/MP-RH project Phase II, September 2010

[11] ASHA (Accredited Social Health Activists): one female volunteer from the community recruited for every 1000 population under NRHM

[12] AWW: anganwadi worker, representing the Integrated Child Development Scheme (ICDS) under the Department of Women & Child Development (DWCD).

One of the sub-centres visited during the field trip was found to have only two rooms, but the two ANMs were able to conduct deliveries besides carrying out outreach activities. Sub health centres started the practice of displaying essential information meant to benefit the community e.g. name of the centre, ANMs' field visit plan, mobile telephone number, Janani Express (ambulance) call centre number, health campaign messages including cash incentives for JSY scheme, etc. The need for organizing the sub-centre to boost the efficiency of frontline health workers and improve the quality of service delivery has culminated in the production of a pictorial guide on the subject in Hindi and in English.

Table 4: Number and infrastructure of SHCs that were accredited to conduct deliveries in the two pilot districts

District accredited sub-centres to conduct deliveres in Damoh and Panna				
Indicator	Damoh	Panna	Total	%
Total number of accredited SCs	18	18	36	
Functional toilet	16	15	31	86
Earmarked corners	13	0	13	36
Basic infrastructure	8	18	26	72
Five trays	9	0	9	25

Source: Joint Terminal Evaluation Report, JICA/MP-RH project Phase II, September 2010

4.3.4 Biomedical waste management:

An increase in the number of institutional deliveries inevitably placed an additional workload and responsibility on the "Infection Management and Environment Plan (IMEP)" of the health facility. Following the GoI

Table 4: Number of CHCs with initiatives/prerequisites for biomedical waste management

Number of CHCs with bio-medical waste prerequisites						
	Districts					
	Damoh	Tikamgarh	Panna	Sagar	Chattarpur	Total
No. of existing CHCs	7	6	6	11	10	16
With colour coded bins	5	1	1	9	0	24
With sharp pits	5	2	6	9	2	17
With deep burial pits	7	0	3	9	1	20

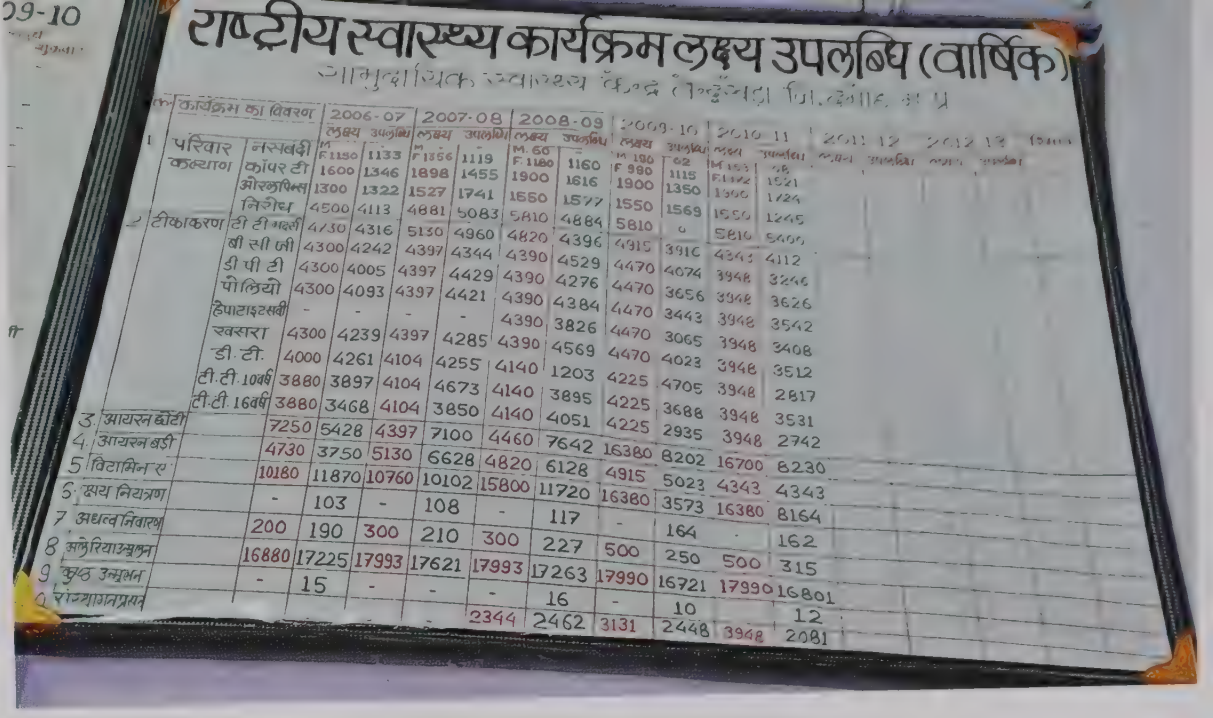
".....Bio Medical Waste Management – JICA project helped us make this work in these districts....."

Response of Mission Director, RCH-NRHM, Public Health & Family Welfare, Government of Madhya Pradesh, Bhopal

Lessons Learnt

"...A journey from nobody's business to everybody's responsibility..."

- **Quality enhancement of the primary health-care service delivery infrastructure and its functioning is essential and achievable by way of engaging health-care providers and all ancillary staff in the process working as a team.**
- **Quality improvement can be achieved through several agreed means.**
- **Management of biomedical wastes was a useful entry point for total quality management (TQM) component of the project.**
- **Managers are available in the system, their abilities need to be recognized and their capacities strengthened – the process calls for catalytic approach by experts who can facilitate TQM.**
- **The JICA/MP-RH project has shown that making knowledge products available, and promotion of "learning by doing" are good practices for quality improvement.**



guidelines for biomedical waste (BMW) management, the project brought the health department and Madhya Pradesh Pollution Control Board (MPPCB) together. This initiative on BMW management was an important and commendable initiative under the TQM component of the project, aimed at reducing hospital based infection and environmental hazards. Changes were made in the erstwhile unhygienic and environmentally unfriendly processes and practises through several activities including the development of guidelines, organizing colour coded containers for segregation of BMW waste at source, making deep burial pits and sharp pits, and conducting seminars for health staff. The project generated several knowledge products that can be used, such as a methodology paper, BMW needs assessment chart, biomedical waste posters, biomedical waste stickers, and models of colour coded bins and deep burial pits. See Table 4.

Quality improvement was also achieved by other initiatives such as introduction of the "quality circle" and functional analysis of health service delivery units (OPD, maternity wing, inpatient ward, NRC, laboratory, waste disposal space, etc.) that were looked at in the light of available "standards" (the IPHS). Managers were available in the system, and this project showed that these managers could be assisted and motivated to manage TQM initiatives and activities.

STORY 3:
A BIRTHING CENTRE IN OUR MIDST! WHAT A RELIEF, WE ARE GRATEFUL!

It can never be adequately described as to how much of a difference it makes to the well being of women by just having a facility for childbirth near to them. The relief brought about and gratitude evoked by birthing centres which were not there before has to be seen to be believed. The story narrated by the documentation team members of what they saw and what the women told them portrays this very well, as seen in Box 3.

We drove through the gravel roads and reached the sub-centre soon after mid day. As we got off the car, we saw a small shop where someone was skinning a chicken. A boy sat with a spread of many dozens of eggs for sale. Inside the shop another person was cooking a spicy chicken curry. A little distance away workers are busy at building site. It was almost lunch time, and the daily labourers trickled into the shop for a quick meal of chicken curry. Some of them also bought a spot of alcohol. The chicken curry was wrapped in pieces of newspaper for some of the labourers.

Right opposite this shop that peddled chicken, eggs, alcohol et al was the sub-centre. It was a very old building divided into two parts. In one section lived the ANM, her husband (himself a male health worker) and her two kids.

We were greeted by two young and bright ANMs. Seeing the JICA staff members who were familiar faces for them, their eyes brightened up even more. They were pleased but curious about the visit. It seemed that they were waiting for us to show off their work, of which they were justifiably proud.

This little nondescript centre had only two ANMs and had been converted into a birthing centre. We couldn't get the opportunity to ask were the second ANM or her family lived. After crossing the ANM's office we entered the next room. There were two beds on both sides of the door occupied by two women who had just delivered healthy newborns. They were very happy that they did not have to travel long distances for the childbirth.

More and more pregnant women are appreciating the usefulness of the birthing centre so close to their homes and villages. They were very happy with the two ANMs who had assisted their childbirths. They were complete faith in them, and believed that the ANMs knew what they were doing and would do their best at their delivery.

We couldn't help but notice the sense of happiness and gratitude on the faces of the mothers and the smiling and flushed faces of the two proud ANMs during the interaction. The ANMs beamed with pride when the mothers narrated their happy experience.

We then went to the labour room where the two women had delivered their babies a few hours ago. We stared at the labour room and couldn't stop tears coming out of our eyes. We wondered why in India better and decent care with quality, dignity and respect cannot be provided to pregnant women? The two mothers indeed had very small expectations. We wondered why society could not provide mothers who put their lives in danger for the sake of continuing their family line the best and the very best? The reality sunk in, and we then looked at the brighter side: at least the mothers there had the services of the two skilled ANMs so close to their village. And they were safe and their babies were alive and healthy. But efforts must continue to provide better quality services, and there was indeed plenty of room for improvement.

"...we studied the situation of reporting ....there were 17 registers, but not standardized, not based on reporting requirement...there was need for orientation of data managers...so we supported out of new HMIS under NRHM..." Response of HRM Consultant, JICA/MP – RH Project

"...moto was data quality...as there was no tool for recording antenatal status and services...so Maternal Health (MH) card was developed... later we started working with DEO (Data Entry Operator) at block and district level...computers were lying in dust....DEO was just a computer literate, they didn't have any clue about what data need to be entered, how to enter...because of JICA Training the DEOs became functional and they understood...now they help BPMs (Block Program Manager) to prepare a better quality report..." Response of HMIS Consultant, JICA / MP – RH Project

4.4 Better data management and supervision

During the ANM training, discussions were held on recording the findings of antenatal check up. It was evident that there was a need for a Maternal Health (MH) Card[13] to be used by ANMs, because the existing card in use ("Jaccha Baccha Card") was unable to capture some essential details which were crucial for providing appropriate optimal care and planning service delivery. During the supervisory visits to sub-centres ANMs expressed their need of understanding the process for manual data entry into registers, based on the RCH/NRHM requirement. This felt need was addressed by the HMIS component of the project.

The HMIS component also strengthened the reporting system by engaging and orienting "data handlers" from various levels, including from sub health centres to the district level. The NRHM has the provision for the recruitment of the data entry operators (DEO) at the block and district level. These DEOs needed a clear orientation on their roles and on the concept of HMIS. Therefore, the district health administration requested JICA to design a training course for them.

[13] The MH Card is the modified version of the Dhanvantari Card developed by the state for selected blocks. The State Government decided to pilot usage of the card in two regions (Sagar & Jabalpur) in the financial year 2008-09

Category	Title	Remarks
Information to the community on services and schemes	10 parameters of ANC check-up	Poster in SC
	Song book for IEC/BCC and audiocassette	In Bundeli (local vernacular) dialect
	Monthly calendar of services	Wall-writing
Health education	Kangaroo method	Posters in Hindi to be displayed in health facilities & AWCs
	Baby wrapping	
	Breastfeeding	
Health Workers Manual for specific communication	How to conduct *Goad Bharai* as a part of safe motherhood initiative	For health workers and AWWs
	Manual for implementation of Husband's Quiz (Hindi)	Targeting Husband's behaviour and Health Workers communication capacity
	VHND operational manual	Steps to be taken by health workers in collaboration with AWWs and PRIs.

"...BPM (Block Programme Managers) – ...the BMO (Block Medical officer) has given lot of responsibility...they don't know what they are supposed to do...they only do what the BMO asks them to do...we worked with few BPMs...later BMO took him as personal assistant...many BPMs left the job..."

Response of Block Coordinator, JICA / MP-RHP

Responses of antenatal mothers

Q: Why do you need to get checked by health workers/doctors during pregnancy?

C) to know whether the baby is at risk.

D) to know if the blood pressure is high

Q: Suppose the BP is high during pregnancy, what would happen?

A) it can affect the baby.

B) the mother also can get affected.

Q: What services have you received from the SC during pregnancy?

B) had injections, also gives tablets for one month.

E) test our blood.

Q: Why blood test is required during pregnancy?

B) if the blood does not test right it can affect both baby and mother.

Q: Is anything else checked during the ANM check-up during pregnancy?

D) weight and height are measured.

Q: Is any examination made by touching your abdomen?

D) Yes, this tells us if the baby is okay.

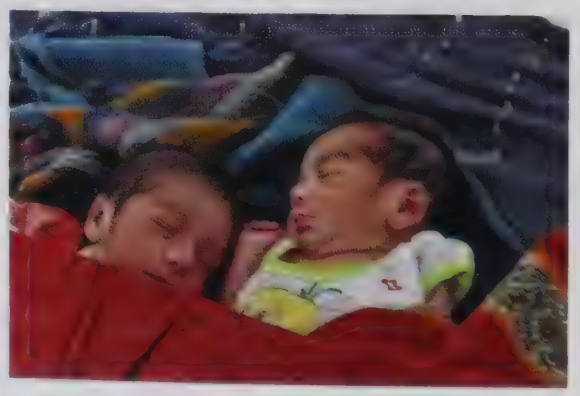
Q: Where do you go for delivery?

A) To the hospital; we get cash for it.

Lessons Learnt:

- For improving HMIS, several inputs were required such as design of an appropriate and adequate patient card such as the maternal health card, registers for data collection and the standardization of reporting formats.
- Differentiation in approach and content is needed according to the different levels – SHC, PHC, CHC, district, state.
- It is very important have a systematic approach to capacity development of manual and computer cadres, and to clarify the roles of each cadre.
- Timely and supportive supervision is critical.
- Use of GIS to transport data is an appropriate and useful technology.

While the DEOs recruited at each block and district level under NRHM were computer literate, they had very little knowledge about health indicators and terminologies/definitions used. There was also a problem related to personnel; the existing data managers such as the Assistant Statistical Officer (ASO) and Block Extension Educators (BEE) who are responsible for collecting, compiling and reporting of data viewed these DEOs as competitors and, therefore, did not extend any cooperation to them. Therefore, the training plan was formulated after due consultations and discussions to take this into account. The old data handlers were oriented on the reporting system in accordance with the new MIES from NRHM; the newly recruited DEOs were imparted orientation in basic knowledge of the HMIS of NRHM/RCH for them to understand health indicators and related terminologies. This approach proved effective and these cadres began to work together after understanding each others' roles.

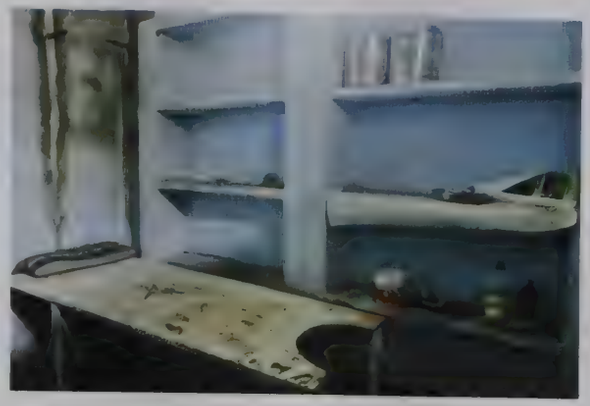


The technical assistance experience at the sub-district level was shared with the National Health Systems Resource Centre (NHSRC) in 2007 during the finalization of the NRHM reporting format. The HMIS manuals for NRHM, published by NHSRC, recognized the contributions of the HMIS and HRM consultants for the project. The lessons learnt in strengthening HMIS for

evidence based project management (EBPM) were shared with the Madhya Pradesh state government through advocacy notes.

The geographical information system (GIS) for microplanning and monitoring the status of the "maternity wing organization'"and "BMW management" was used by the project. The GIS package was handed over to the health department following training.

There was evidence that the project has made a difference in the abillity of the block coordinators to conduct supportive supervision. Efforts were also planned for transferring knowledge and skill on supportive supervision to BPMs (appointed under NRHM), but this could not be pursued to be extent desired because only a few of them remained in the system. It was not within the capacity and purview of the project to ensure the retention of trained staff.



4.5 Demand generation and perception of the community

The project facilitated the RCH/NRHM strategy of community engagement for demand generation of RMNCH services through enhancing the communication and organizing skills of ANMs as leaders to organize community events such as Village Health and Nutrition Day (VHND)[14], This effort, coupled with other events like *Goad Bharai*[15] and Husband Quiz[16], was carried out as a way of engaging men and through them reaching out to a larger community to develop a better understanding on the need of antenatal care for family members and the importance of newborn care and child health. These efforts also engaged the male multipurpose worker (MPW) and the supervisers in supporting the ANM. The experiences led to the development of knowledge product such as the "Operational Manual for VHND Organizing" and a video on VHND. Under IEC/BCC component, a few more knowledge products were produced as follows:

This component could have provided more emphasis on service providers' communication skills to enhance various community stakeholders' understanding about MNCH services, and could have designed materials and methods to dispel any myths and misconceptions.

Interaction with women in the reproductive age group, including antenatal mothers who use the health services provided by the sub-health centre, revealed that they are aware about the importance of antenatal check-up and the procedures carried out, such as estimating the height, weight,

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[14] VHND: Village Health and Nutrition Day

[15] Goad Bharai: A traditional practice of celebrating pregnancy and wishing for the good health & long life of both mother and baby by gifting the pregnant woman auspicious items. DWCD adopted this tradition as a part of Mangal Diwas (auspicious day) on the first Tuesday of the month. JICA project introduced nutrition counseling and ANC services as additional activities of Goad Bharai

[16] Husband Quiz: The aim was to enhance husbands' awareness, sensitivity and attitude towards their pregnant wives

Lessons learnt

- Community mobilization is an essential component of maternal and child services, and there are several methods of mobilizing the community.
- Demand from the community as potential users of the services needs to be created and sustained by their involvement in planning.
- Human relations and respect for the client and her dignity will increase the use rate of services.
- While skills of providers is crucial, it is also to be recognized that there is the need to ensure basic dignity to all women through provision of services that are not compromised in terms of quality and are "women-friendly".

BP, Hb level, and conducting urine test and abdominal examination for fundal height, etc. Some of the respondents, however, could not express why and how many check-ups are required during pregnancy. The women who had delivered their babies in the sub-health centre in the project area were happy about the availability of the service close to their village.

In a district that was not part of the project, women expressed the need for having maternal, and especially delivery services to be made available in the respective SHCs in their villages. Some of the women recognized the fact that the reduction in the number of home deliveries was due to the incentives (JSY scheme) and availability of free emergency transport (Janani Express) made available by the government. Many women started coming on their own to the "24x7" health facilities for antenatal check-ups or to seek services for their children. With enhanced awareness of mothers through the work of the ASHAs, AWWs and ANMs, that was further boosted with these kind of incentives (JSY), access and use will improve but there is still need for a change in attitudes towards seeking health services early during and after pregnancy. It is also necessary to dispel myths and misconceptions that negatively influence maternal and newborn health.

5

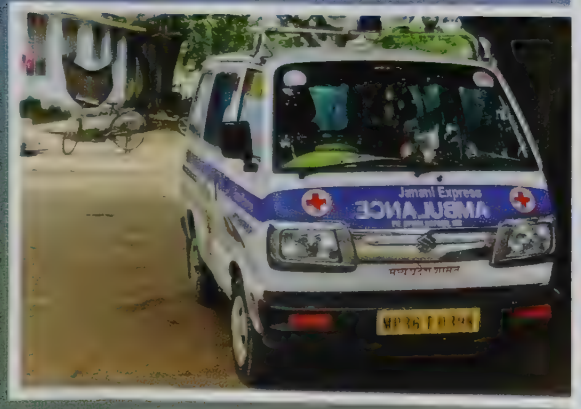
DISCUSSIONS

DISCUSSIONS

In the area of knowledge and skill enhancement of human resources, the six-day training conducted for staff nurses, ANMs and LHVs on SBA and a two-day training on core competency for ANC has been found to be effective, and considered worthy of emulation by the whole state

The JICA/MP Reproductive Health Project (JICA/MP–RHP) has successfully aligned itself with and contributed to the efforts and initiatives of the Madhya Pradesh government in improving the quality of services for maternal health. JICA has adhered to its policy of providing technical cooperation, with no direct financial support such as payment for human resources or purchases of major equipment. The financial support that was provided by the project was restricted to purchase of minor material and equipment such as tools for measuring of blood pressure and haemoglobin, etc, which were deemed as critical for the project.

Strategically "starting small"' with a scale-up plan, the project has produced results that will improve maternal and newborn health in the project area. More significantly, the project was able to align itself with the framework of the RCH-NRHM initiatives of the government and, in doing so, has contributed to several aspects of these initiatives. Certain features of the NRHM had a strong influence on the output and outcomes of the project, in particular the role of the conditional cash transfer scheme of the JSY that had led to a significant increase in the number of institutional deliveries. In short, there was clear synergy and mutual benefits between the NRHM and this project.



In the area of **knowledge and skill enhancement of human resources**, the six-day training conducted for staff nurses, ANMs and LHVs on SBA and the two-day training on core competencies for ANC has been found to be effective, and considered worthy of emulation by the whole state. The project also optimized whatever was available. For example, the ANM Training Manual previously developed by the State in collaboration with UNICEF was

adopted with minimum modification. New tools and training methods that had been developed and tested were shared with SIHMC and three RHFWTCs for state-wide expansion. The TOT at the higher level training institutions needed to go beyond clinical skills, and it included planning, management and monitoring of training courses. There is clearly durability and sustainability and transfer of technology, as shown by the fact that more than half of the 382 ANMs/LHVs of Damoh and Tikamgarh districts trained on core competencies are now conducting regular ANC services. A DVD/VCD based on location in an average SHC in Damoh was produced for further dissemination and standardization of the ANC activities. This has been shared with all the district IEC consultants. This is an aspect that was clearly spelt out in the project objectives right from the planning stage.

The skill-building of the ANM was an appropriate focus and entry point. Besides the technical skills imparted, there were inputs on improving their management, data-handling, communication and supervision capacities. It was significant that when stakeholders both from within the project itself as well as in the government health hierarchy were asked about the most striking outcome of the project, they were unanimous in listing ANM skills and confidence.

Their skills and confidence in using the untied funds of the NRHM appears to be a recurring theme in the fact-finding mission. However, it was noteworthy that with the adoption of the clear policy for the project to align its activities and approaches with the needs of the health system, the six-day training was reduced to a two-day ANC core competency training course. This reduction in the duration of training was not done randomly, the project conducted a field test on the model in two districts to see that it was indeed acceptable and appropriate.

In facility management and upgrading, even though the project did not have the capacity or mandate to purchase major equipment, the project promoted the management and organization of SHCs utilizing existing resources, especially the untied funds of NRHM. Health staff in charge of maternal health in PHCs/CHCs were assisted in organizing the maternity wing (including the labour room), and in doing so, efforts were made to use the standards of the IPHS. These practices in upgrading facilities are also likely to be sustainable, especially with better skills and confidence in using the untied funds of NRHM made available to ANMs .

In the area of **management of biomedical wastes** as the entry point for TQM, the project took the initiative to coordinate between the state government of Madhya Pradesh and

The skill building of the ANM was an appropriate focus and entry point. Besides the technical skills imparted, there was input into improving their management, data handling, communication and supervision capacities

Various inputs of the project have led to the achievement of the project purpose, which as stated in the PDM was "to increase the number of pregnant women and mothers who receive quality maternal health services by using nursing cadres, with special emphasis on ANMs"

Madhya Pradesh Pollution Control Board for the purpose of promoting IMEP practicable in field conditions. As a result of several joint workshops and consultations, many CHCs/PHCs in Damoh and Tikamgarh have now adopted BMW management as a routine activity, and those can be used as model for others. The other quality improvement initiatives besides BMW management were the given from the project that will be long-lasting. These women explained if the project had successfully inculcated the culture of quality to health providers at all levels.

Information management is another area in which the project made a noticeable difference. Aiming at streamlining the existing information system, the project had proposed many practical measures to the state. The project played a useful role in being the "bridge" between NHSRC and the state for the design of new recording and reporting formats, which instilled a sense of pride in the project team members. All the DEOs in the five districts who were trained in data-handling and management will be able to function better in their tasks, and will eventually contribute to the improvement of the maternal health status of the area. The GIS would also be extremely useful for evidence-based planning and management, a step that could not be fitted into the project due to its limited duration.

In the area of **demand generation, through IEC/BCC and outreach services**, the coordinating role played by the project among stakeholders

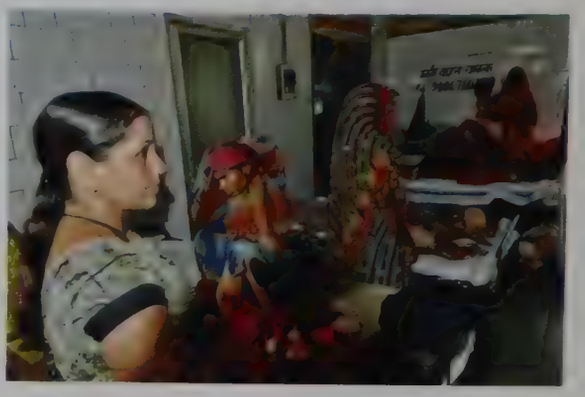
will continue to strengthen this aspect of health care. These areas can now benefit from the various products of the project such as the Village Health and Nutrition Days (VHNDs) and the various DVDs/VCDs produced. However, several respondents felt that more could have been achieved in this regard if an expert was hired full-time.

All these various inputs of the project led to the achievement of its purpose, which as stated in the PDM was "to increase the number of pregnant women and mothers who receive quality maternal health services by using nursing cadres, with special emphasis on ANMs". In achieving this maternal element of the service, newborns simultaneously benefitted as well, because the maternal-newborn dyad is a biological and social link that cannot be seen as separate from each other. The training of ANMs has made a major difference in the performance at SHCs. Even when the number of ANMs trained had not reached a high figure (18% only as of December 2010), the proportion of deliveries conducted by SBAs had significantly increased, suggesting that many more mothers were delivering at the PHC and CHCs.

There were, needless to say, challenges in the implementation of the project, the major ones being related to weaknesses in the health system, a common feature in most developing countries. This was characterized by severe shortage of health service providers; lack of supportive supervision and supervisers at the district and block level; insufficient or inadequate skills of staff to provide good quality MNCH services; some health facilities being only partly functional due to poor health infrastructure and management difficulties; and inadequate data management for evidence-based planning. All these led to poor utilization of health services by the target population.

The factors that may have positively influenced the project include being able to negotiate a different operational arrangement according to the changes that occurred in national strategies and policies; the project Chief Adviser's ability to put together a team of local experts who could work as a team to achieve a common goal; continuous efforts to achieve a "quality standard" based on available guidelines and by engaging service providers and managers to aspire to the highest possible level of quality; and supportive supervision and on-the-job training for the block coordinators and technical specialists to enhance the level of confidence of frontline service providers.

The factors that may have negatively influenced the project outcome include the long process required in operationalizing the project and delay



in firming up the inputs; non-availability of consistent M&E indicators, and inadequate resources in the budget for impact evaluation; absence of a strong advocacy element and dedicated personnel in the team; absence of IEC/BCC experts in the team; non-availability of staff at various levels in the health system in Madhya Pradesh; and poor engagement male workers and supervisers.

Several stakeholders expressed the opinion that the abrupt closure of the project without a phased-out plan was unfortunate. They felt that while the project had an overall positive outcome, its duration was not long enough to produce an impact. It is unfortunate that the project ended before some of the weak elements could be adequately addressed. These included newborn care, IEC/BCC for community engagement, supportive supervision and use of information for evidence-based planning.

Strong views were also expressed on the fact that while the project has led to

On the whole, the approach of the project – as characterized by its practicability and scalability; and its ability to work alongside and in alignment with changing policies of the government such as the introduction of NRHM – is a major factor that led to its success

many positive outcomes, it was by its very nature and scope not able to bring about other bigger changes in the health system that could have made a real difference in the status of reproductive maternal and newborn health, such as human resource and health facility development.

It was recognized that while it would have been beneficial, it was not possible for as an externally funded project, such as this project funded by JICA, to address infrastructure problems and human resource shortage. It was also reognized that the project, on the other hand, was able to promote and facilitate the optimal use of resources made available through RCH and NRHM in strengthening the maternal and newborn healthcare services delivery. It was also expressed frequently that health providers had a "fear" that the success of the project would lead to more demands from the community, and indeed is likely to continue to create greater demand, and that this would be a challenge for the health system, which may not be able to cope given its existing limitations of human resources, infrastructure, supplies, management and supervision.

On the whole, the approach of the project as characterized by its **practicability** and **scalability**, and its **ability to work alongside and in alignment with changing policies of the government** such as the introduction of NRHM, is a major factor that led to its success. Despite the inherent difficulties in this rural part of Madhya Pradesh, the project was completed within a short duration. Several lessons can be learnt from the management and leadership of this project, especially with regard to team spirit, effective leadership, supportive supervision, the sense of belonging, the sense of pride among team members, and the quest for attaining the highest level of quality.

6

CONCLUSIONS

Conclusions

The success of Madhya Pradesh in improving health and survival of women and newborns is entirely a government led effort

Government of Madhya Pradesh provided policy and strategic directions as well as invested in improving health and survival of mothers and new borns.

Overall the JICA/MP-RH project complemented government efforts significantly in improving maternal and newborn services in the project area. The project was successful in optimally using the resources made available through RCH and NRHM. Some of the experiences and products of the project can serve as "lessons learnt" and models of "good practices" in maternal health.

ANNEX 1: Project Design Matrix (PDM)

Reproductive Health Project In The State Of Madhya Pradesh (Phase 2)
Version 1 (tentative) Date: 14 May 2009

Project Duration: 17 January 2007 to 16 January 2011 (four years) **Project Area:** Sagar Division (districts of Chattarpur, Damoh, Panna, Sagar and Tikamgarh);
Target Group:

NARRATIVE SUMMARY	VERIFIABLE INDICATOR	MODE OF VERIFICATION	IMPORTANT ASSUMPTIONS
OVERALL GOAL			
The state health sector ensures quality mother and newborn child health services.	MMR at the state level	SRS (Sample Registration System)	• Operational guidelines of RH developed by the project are adopted by the State of MP. • NRHM/RCH-II continues
PROJECT PURPOSE			
To increase the number of pregnant women and mothers who receive quality MH services by the nursing cadres, with special emphasis on the ANMs.	No. of pregnant women who received at least three ANC check-ups	ANM Register reviewed by BMO Register of CHCs/PHCs and MH card	
OUTPUTS			
1. ANMs and related cadres* are capacitated to conduct quality health services	No. of ANMs/LHVs who acquired basic SBA knowledge/skills No. of ANMs who acquired knowledge/skills of core competency	Test after completion of the training courses; MH card; partograph	
2. The workplace environment is improved for the quality MCH services at the health facilities (SHCs, PHCs and CHCs).	No. of health facilities qualified by the standard criteria**	Reports by districts and RJD office, Sagar	
3. ANMs become effective data managers.	No. of ANMs/LHVs reporting regularly using proper formats No. of Blocks performing Programme review based on validated data No. of supportive supervision visits from the block level	Block/District programme Review Reports,	
4. ANMs' communication capacity is enhanced.	No. of VHND held	Project Record	
5. Project achievements and lessons learnt in the pilot area are disseminated and scaled up to the project aera.	No. of districts where project achievement is introduced	State Report	

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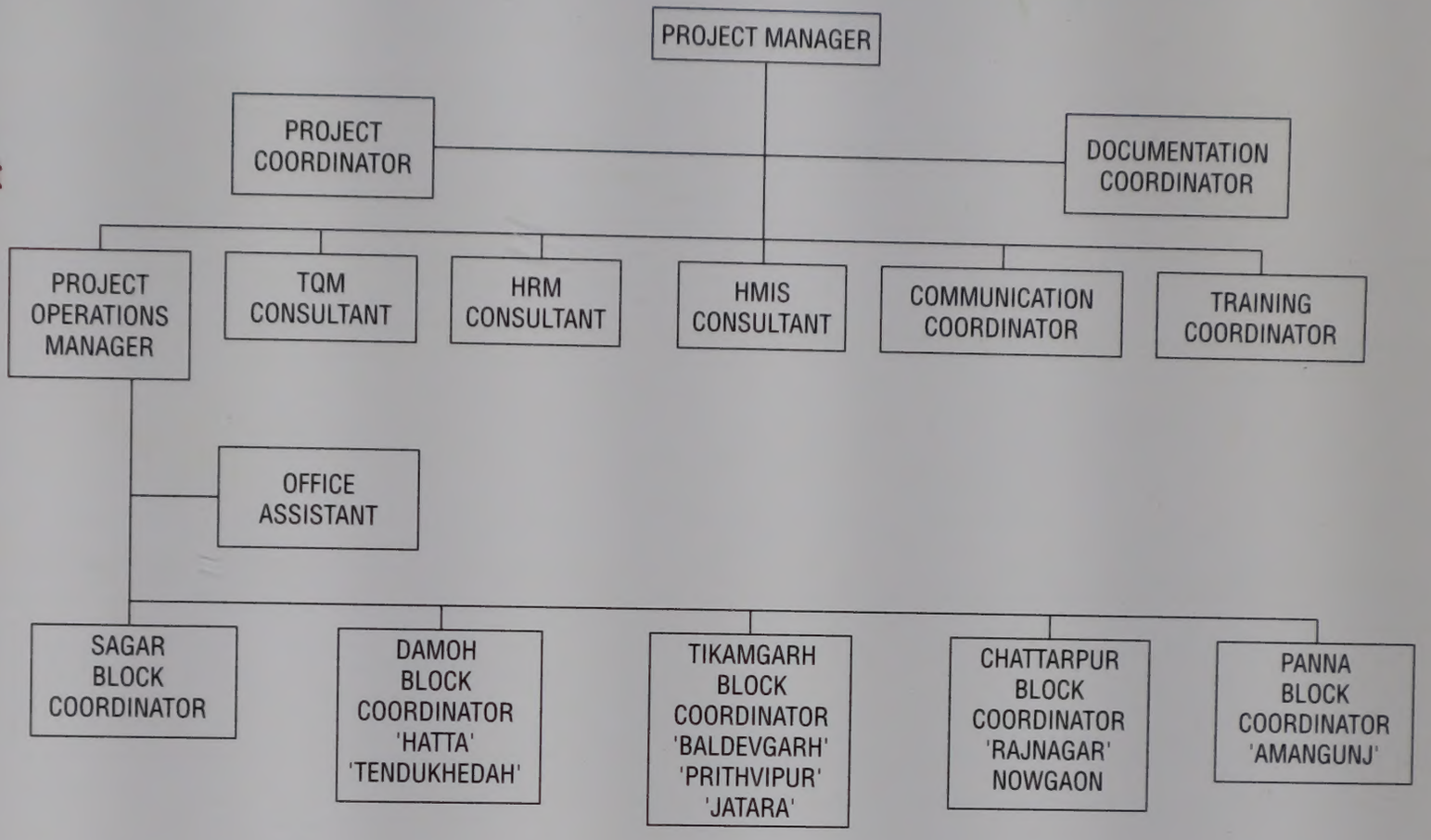
NARRATIVE SUMMARY	VERIFIABLE INDICATOR	MODE OF VERIFICATION	IMPORTANT ASSUMPTIONS
ACTIVITIES	**INPUTS**		
	by GoI and GoMP	**by JICA**	
1.1. To train the trainers of the district ANMTC on training management and monitoring in collaboration with SIHMC 1.2. To conduct in-service training courses for ANMs/LHVs on SBA including core competency 1.3. Periodical assessment of knowledge/skill acquisition by the trained ANMs/LHVs 1.4. To promote job sharing between ANMs and MPW-Males in the pilot area 1.5 To create pilot model for supportive supervision	Project C/P=Department of Health and Family Welfare, GoMP – Health Commissioner, – DPH – JD-RCH – JD-Planning – Deputy Director Gynecology – Director, IEC Bureau – Regional Director, Sagar	JICA experts: Long-term – Health sector planning; Long-term – Project Coordinator cum HMIS; Short-term (TQM, nursing/ midwifery, gender & social studies) Local consultants: (nursing & midwifery, TQM, HMIS, IEC/BCC). Training in Japan (TQM)	RCH-II and NRHM programmes continue up to the end of the project.
2.1. To facilitate DPMs/BPMs for equipment supply and logistics 2.2. To promote rational layout of the maternity wing of CHC/PHC 2.3. To promote total quality management at PHCs/CHCs	Office space	Running cost (minor construction, minor equipment, in-country training, consultants)	
3.1. To streamline procedures for data collection and reporting by ANMs and MPW-Males 3.2. To conduct training courses on information management to Block Health Managers 3.3. To promote HMIS (including GIS) for performance review at the block level	Running cost of C/P		
4.1. To develop IEC/BCC materials in collaboration with the State IEC Bureau 4.2. To promote collaboration between the local health promoters (ANMs, MPW-Males, AWWs, ASHAs, etc.) 4.3. To conduct IEC/BCC campaigns on Safe Motherhood Initiative			
5.1 To conduct dissemination events (workshops, seminars)			
5.2 To promote peer learning (including exposure visits)			

Note: Pilot area = Damoh district (Hatta and Tendukheda blocks) + Tikamgarh district (Prithvipur + Valdevgarh blocks)
* Related cadre: LHVs, MPW-males, Male supervisers
** Standard criteria: Arrangement of four corners and five trays as per IPHS.

ANNEX 2

JICA MP Reproductive Health Project Organogram



ANNEX 3

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ACRONYMS

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ANMTC	Auxiliary Nurse Midwife Training Centre
ASHA	Accredited Social Health Activist
ASO	Assistant Statistical Officer
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BEE	Block Extension Educator
BMO	Block Medical Officer
BMW	Biomedical Waste
BP	Blood Pressure
BPHN	Block Public Health Nurse
BPM	Block Programme Manager
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHC	Community Health Centre
CRM	Common Review Mission
CSSM	Child Survival and Safe Motherhood
DANIDA	Danish International Development Agency
DEO	Data Entry Operator
DFID	Department for International Development
DoH&FW	Department of Health and Family Welfare
DoPH&FW	Department of Public Health and Family Welfare (Madhya Pradesh)
DPHNO	District Public Health and Nursing Officer
DPM	District Programme Manager
DPs	Development Partners
DWCD	Department of Women and Child Development
EC	European Commission
EmOC	Emergency Obstetric Care
FRU	First Referral Unit
GNM	General Nurse Midwife
GoI	Government of India
GoMP	Government of Madhya Pradesh
GIS	Geographical Information System
Hb	Haemoglobin
HMIS	Health Management Information System
HRM	Human Resource Management
ICPD	International Conference On Population and Development
IEC	Information, Education and Communication
IMEP	Infection Management and Environment Plan
IPHS	Indian Public Health Standards
JICA	Japan International Cooperation Agency
JSY	Janani Surakshya Yojana
LHV	Lady Health Visitor
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MH Card	Maternal Health Card
MIS	Management Information System
MNCH	Maternal, Newborn and Child Health
MO	Medical Officer
MP	Madhya Pradesh
MPPCB	Madhya Pradesh Pollution Control Board
MPW	Multipurpose Worker
MTR	Mid-Term Review
NFHS	National Family Health Survey
NIHFW	National Institute of Health and Family Welfare
NHSRC	National Health System Resource Centre
NIPI	Norway India Partnership Initiative
NMR	Neonatal Mortality Rate
NRHM	National Rural Health Mission
OPD	Outpatient Department
PDM	Project Design Matrix
PMNCH	Partnership for Maternal, Newborn ANC Child Health
PNC	Postnatal Care
POA	Programme of Action
PPP Model	Public-Private Partnership Model
PRI	Panchayati Raj Institution
QCC	Quality Control Circle
RCH	Reproductive and Child Health
RFWTC	Regional Family Welfare Training Centre
RH	Reproductive Health
RIHFWTC	Regional Institute of Health and Family Welfare Training Centre
RMNCH	Reproductive, Maternal, Newborn and Child Health
RMNH	Reproductive, Maternal, Newborn Health
SBA	Skilled Birth Attendant
SHC	Sub-Health Centre
SIHMC	State Institute of Health Management and Communication
SIHFW	State Institute of Health and Family Welfare
SOP	Standard Operating Procedure
TOT	Training of Trainer
TT	Tetanus Toxoid
TQM	Total Quality Management
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VHND	Village Health and Nutrition Day
WHO-SEARO	World Health Organization, Regional Office for South-East Asia
WCD	Women and Child Development

World Health Organization

Regional Office for South-East Asia

JICA

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